

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

17928

**1. PLACE OF DEATH**

County Jackson  
Township 11 Can  
City N. Colo

Registration District No. 399  
Primary Registration District No. 700

File No. 2067  
Registered No. 2067  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence No. 1412 Colorado St., 12 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Fe 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edwin Miller

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20-1845

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
85 9 14

8. OCCUPATION OF DECEASED Housewife  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT (Address) Mrs Violet B. Steffer 1412 Colorado

15. FILED 5/5 1931 M. M. Cerone REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 4 1931

17. I HEREBY CERTIFY, That I attended deceased from 3-10-1931 to 3-3-1931 that I last saw her alive on 5-3-1931, and that death occurred, on the date stated above, at 4:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Arteritis obliterans

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 8 ds.  
CONTRIBUTORY Arterio Sclerosis

(duration) 1 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF BIRTH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) Tom Sawyer M. D.

May 4, 1931 (Address) 17th & Jackson Ave

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Grav. Iowa DATE OF BURIAL May 5 1931

20. UNDERTAKER Boyle & Henderson ADDRESS City

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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